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Juvenile Correctional Workers' Perceptions of Suicide Risk Factors and Mental Health Issues of Incarcerated Juveniles

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Abstract

Correctional staff knowledge, attitudes, and perceptions of incarcerated juveniles' mental health needs, including suicide prevention, have not been studied empirically. This study measured juvenile correctional officers' knowledge and attitudes regarding suicide risk factors and mental health and substance abuse issues through administration of the Mental Health Knowledge and Attitude Test (MHKAT) before and after a staff training on suicide prevention. Seventy-six participants completed the pre- and post-training MHKAT. They demonstrated significant improvement in knowledge of and attitudes toward mental health treatment of incarcerated youth as reflected by higher post-training MHKAT scores. Findings suggest that correctional staff are receptive to increasing knowledge of critical mental health issues. Studies of the retention and implementation of this new knowledge by direct care staff over time and the optimal type and frequency of new staff training and continuing education are indicated.

Introduction

Approximately one million youth enter the juvenile justice system (JJS) every year, with estimates of 100,000 youth placed into juvenile correctional facilities (Snyder & Sickmund, 1995). Numerous studies have documented the higher prevalence of mental disorders and emotional and behavioral problems among youth in the JJS as compared to the general population (Domalanta, Risser, Roberts, & Risser, 2003; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). It is estimated that 50% to 70% have psychiatric and/or substance use disorders (Teplin et al.).

Although no current national data exist regarding the incidence of suicide attempts among youth in juvenile or adult custody, the information available suggests a high incidence of suicidal behavior in juvenile correctional facilities. More than 11,000 juveniles are estimated to engage in more than 17,000 incidents of suicidal behavior in juvenile facilities each year

(Domalanta et al., 2003). Reported rates of current suicidal ideation in incarcerated adolescents range from 14.2% to 51% (Timmons-Mitchell et al., 1997; Kataoka et al., 2001). Reanalysis of suicide rates in a national survey of juvenile suicides found that suicide in juvenile detention centers was estimated to be more than four times greater than in the general population (Memory, 1989). These figures strongly indicate the need for specialized mental health care for these adolescents.

Both the National Commission on Correctional Health Care (NCCHC, 2004) and the American Correctional Association (ACA, 2004) have established national standards that guide mental health evaluations in correctional settings. Both emphasize the importance of timely intake screening, with the NCCHC standard for juvenile settings specifying that receiving screening take place upon the juvenile's arrival at the facility, with urgent needs, including potential for suicide, addressed immediately. Further, while the NCCHC standard recommends that health professionals conduct the initial screening, child care workers may do so provided that they have appropriate health training.

There may be additional state or county designations regarding the specifications of this screening process, evaluator qualifications, and the timeline for a more comprehensive clinical evaluation by a qualified mental health professional, typically within two weeks of incarceration.

The role of the correctional officer in the assessment and treatment of youthful offenders has received renewed attention. Some correctional experts have proposed that, due to the increased volume of youth with mental health issues, limited budgets for hiring additional clinical professionals, and the amount of direct contact that correctional officers have with youth, it is necessary and feasible to train correctional staff to serve as adjunct treatment staff while still fulfilling their security functions (Holt, 2001). Although the ACA standards do not detail the content or amount of training correctional officers should have, they do note that officers must receive training on suicide prevention and mental health crisis (2004). NCCHC has developed an overview of training for correctional health care staff that incorporates the unique health, developmental, and educational needs of adolescent youth (2004).

Research suggests that correctional staff may effectively serve as adjunct treatment staff. Training and integrating correctional officers into therapeutic communities (drug treatment programs) has resulted in a decreased incidence of behavior problems and violence in these facilities (U.S. Department of Justice, 1996). Given limited financial resources and the increasing number of juvenile offenders in correctional facilities, expanding the treatment team to include the correctional officer may be the best and most effective means of addressing this problem (Holt, 2001). Consultation between security and health care staff on medical and security issues furthers the development of a collaborative work environment (Fewell, 1988).

It is generally recognized that an understanding of the youthful offender and knowledge of mental health problems that arise during incarceration are required to be an effective member of the treatment team. To date, there has been no national training initiative for juvenile correctional officers or other direct care staff who are involved in the intake assessment and care of incarcerated juveniles. Adolescents are often admitted to correctional facilities after hours when few or no clinical staff are on site. Direct care correctional staff with varying levels of skill, training, and motivation are relied on to identify youths with potential mental, emotional, or behavioral problems at entry points in the juvenile justice system. Due to a national shortage of child and adolescent psychiatrists and other mental health professionals (Parent et al., 1994) and the increased emphasis on cost containment in juvenile correctional facilities nationwide, reliance on direct care staff to screen and identify at-risk youth for further clinical evaluation will continue.

As juvenile correctional facilities become increasingly dependent on correctional workers to screen and identify at-risk youth, it is important to collect information on staff perceptions, attitudes, and knowledge regarding the mental health needs of incarcerated juveniles. Juvenile correctional workers' knowledge base, attitudes, and perceptions of these mental health needs—specifically self-mutilatory behavior and suicide attempts—have not yet been studied empirically.

In the present study, a survey was created to examine correctional workers' mental health knowledge and attitudes towards incarcerated juveniles. This survey was based on the existing literature on suicide prevention in juvenile correctional facilities (Hayes, Loughran, Godfrey, Maziarz, & Nasiakos, 1999; NCCHC, 1999). The instrument was administered both prior to and following a mandatory training on the mental health treatment of incarcerated juveniles. Specifically, the survey sought to examine baseline knowledge and attitudes prior to any targeted training. Secondly, it examined whether mental health knowledge and attitudes improved as a function of the training.

Methods

Participants

Study participants were the 83 juvenile correctional workers who attended one of three mandatory training sessions for all juvenile correctional officers who work in Rhode Island's sole juvenile correctional facility. The participants are employed by the Department of Children, Youth, and Families (DCYF), a state social service agency. The age of participants ranged from 24 to 62 years ($M = 37.4$, $SD = 9.4$).

Table 1 shows participant demographics and background characteristics. The majority of participants were male. More than half held at least a bachelor's degree and reported substantial work experience as a juvenile correctional worker (7 years or longer). Approximately one third of participants reported prior work experience in a mental health setting or in a medical setting, and more than one fourth reported prior clinical training. Few participants had previously worked for the state social welfare agency, but approximately one third reported a career interest in social services. Nearly one half reported a career interest in law enforcement.

The medium-security facility where this study was conducted admits approximately 1,100 youth per year, including some recidivists. All youth are sent to the facility by the state family court. The average time served is 6.1 months. Youth are incarcerated for a variety of violent and nonviolent offenses including, but not limited to, arson, robbery, drug-related crimes, murder, manslaughter, sexual assault, child molestation, burglary, and stolen motor vehicle. On average, approximately 20% of youth housed at the facility are preadjudicated (pretrial) and 80% are adjudicated (sentenced).

Medical and mental health services are provided on site. A board-certified child psychiatrist is available to provide diagnostic evaluations and pharmacotherapy. Adjudicated youth also may receive individual, family, and/or group therapy, as well as other court-imposed or offense-specific treatments (e.g., substance use disorders, sexual offending).

Procedures

All participants attended a facilitywide staff training on the mental health treatment of incarcerated juveniles, specifically suicide prevention, screening, and referral. The first author conducted the one-time presentation based on current NCCHC recommendations as well as strategies proposed by experts in correctional suicide prevention (Hayes et al., 1999; NCCHC, 1999). The information included prevalence and phenomenology of mental and substance use disorders in incarcerated juveniles, suicide attempts and risk factors in these youths, and

identification and prevention approaches for correctional staff. Permission to collect questionnaire-elicited data before and after the training program was obtained from facility administration. No facility or department administrators were present during any portion of the training or the administration of the pre- or post-training instruments. The correctional officers were asked to complete the measures anonymously and were informed that they could decline to participate at any time. No potential participants declined to participate.

Measures

Because there is no existing literature or any validated instrument that assesses knowledge base or correctional officers' attitudes or perceptions regarding suicide risk factors and mental health issues of incarcerated juveniles or adults, the first author designed pre- and post-training questionnaires based on the current literature on suicide prevention in juvenile correctional facilities (Hayes et al., 1999; NCCHC, 1999).

Mental Health Knowledge and Attitude Test (MHKAT)

The MHKAT is a 12-item test designed to measure knowledge of and attitudes toward mental health treatment of incarcerated juveniles. The pre-questionnaire consisted of basic demographic information, including age, sex, education level, and number of years working in a correctional facility, as well as 12 questions/statements in which respondents were asked to circle responses on a 4-point Likert scale (strongly agree, agree a little, disagree a little, strongly disagree). A total knowledge and attitudes score is calculated from these items. Negative items are reverse scored and then added to positive items to create a total score. Higher scores reflect greater knowledge of and more positive attitudes toward mental health treatment for incarcerated youth. Immediately after the training session, the same 12 questions/statements were administered as the post-training test.

Results

Preliminary Analyses

Seventy-six participants completed the MHKAT prior to the mental health training. Differences in pre-training knowledge and attitudes by background characteristics were examined through a series of *t* tests. As reflected by their total MHKAT scores, participants who reported greater knowledge of and more positive attitudes toward mental health treatment for incarcerated youth were those who previously worked for the DCYF ($M = 68.56$, $SD = 3.47$ vs. $M = 64.58$, $SD = 4.94$; $t = 2.32$, $p < .05$), previously worked in a mental health setting ($M = 67.32$, $SD = 3.38$ vs. $M = 64.02$, $SD = 5.13$; $t = 2.73$, $p < .01$), and/or had prior clinical training ($M = 67.75$, $SD = 3.13$ vs. $M = 64.17$, $SD = 5.10$; $t = 2.63$, $p < .05$) versus those who did not.

Bivariate correlations also revealed a positive association between age and total MHKAT score ($r = .28$, $p < .05$). Gender, education level, time employed as a juvenile correctional worker, a career interest in social service, a career interest in law enforcement, and previous work in a medical setting were not found to be related to pre-training knowledge of or attitudes toward mental health treatment of incarcerated youth.

Pre- and Post-Training Analyses

Seven juvenile correctional workers arrived late to the training and did not complete the pre-training MHKAT. Thus, 83 completed the post-training MHKAT. Due to participant concern regarding confidentiality, no names or other identifying information appeared on the test forms and so pre- and post-training MHKAT scores could not be matched by participant.

An independent sample *t* test was conducted to examine differences across pre-training and post-training groups on the MHKAT total score. The post-test score was slightly higher ($M =$

66.7, $SD = 3.1$) than the pre-test ($M = 65.1$, $SD = 4.8$). This difference was statistically significant, $t(138) = 2.25$, $p < .01$.

In addition, 2×4 chi-square analyses were conducted to examine change in individual MHKAT items from pre- to post-training. Results are presented in Tables 2 and 3. Upon completion of the training, participants were more likely to report that youth involved in the juvenile justice system have more mental health problems than noninvolved youth; that risk factors for suicidality are upon transfer for a court appearance, confinement in isolation/segregation, sentencing, receipt of new legal charges, and a prolonged stay at a juvenile facility; and that better mental health treatment furthers rehabilitation for JJS-involved youth.

Discussion

The first goal of this study was to examine the knowledge base and attitudes of juvenile correctional workers toward incarcerated juveniles' suicide risk factors, mental health needs, and clinical referral issues. Overall, there was a generally positive attitude toward mental health problems and treatment needs of detainees. At the pre-test, most participants had favorable attitudes toward mental health intervention. One possible reason why the juvenile correctional workers in this facility had relatively positive attitudes might be because they were employed by the state social service agency for children, youth, and their families rather than a juvenile correctional agency. In this capacity, they may have had more exposure to mental health issues and related training opportunities.

Because there is no existing literature describing differences in training, continuing education, and attitudes regarding incarcerated juveniles' mental health issues between juvenile correctional staff employed by state social service and juvenile correctional agencies, regardless of funding source (e.g., public or private), additional research is warranted.

The majority of study participants strongly agreed that more mental health services are needed for youth involved in the juvenile justice system, and that substance abuse education and prevention and formal mental health screening are important. Similarly, the majority felt that screening and evaluation are important for suicidal JJS youth. Post-training test results showed a positive shift in attitudes that mental health care improves rehabilitation. In addition, after training, more juvenile correctional workers agreed that JJS youth have more mental health problems than non-JJS youth.

Knowledge of suicide risk factors was less consistent. Specifically, the juvenile correctional workers initially were in less agreement regarding the identification of various high-risk periods for suicidal ideation or suicide attempts during incarceration. After training, there was greater recognition that juveniles' risk of suicidality increases upon transfer for a court appearance, receipt of a new legal charge, and a prolonged stay in a facility.

Overall results of this study suggest that knowledge of mental health issues and attitudes towards mental health treatment of incarcerated juveniles do improve as a function of facilitywide mental health training. This improvement is notable considering that only one training session was provided. Future research might examine retention of knowledge over time and whether this additional mental health education translates into meaningful behavior change in correctional staff's interaction with incarcerated juveniles.

There are several limitations to this study. First, the sample population was limited to one juvenile correctional facility. This raises questions about the generalizability to other juvenile correctional facilities nationwide. Second, juvenile correctional workers may have answered items in a socially desirable direction. A measure of response bias to help examine this possibility was not included. However, since the questionnaires were anonymous, misreporting

likely was minimal. Third, the measure used in this study has not been used before and does not appear to be particularly sensitive to change following instruction. Because so many items were rated highly at baseline, there was relatively little room for improvement following training. Fourth, the study design did not allow juvenile correctional workers' pre- and post-training tests to be linked so intraindividual change due to training could not be examined.

Further studies are needed to elucidate juvenile correctional workers' knowledge base, attitudes, and perceptions regarding incarcerated juveniles' specific risk factors for suicide attempts and self-mutilative behaviors, mental health disorders, and substance use disorders. Although there is emerging scientific literature on the use of the MAYSI (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001) and other self-administered screening instruments, additional studies are necessary to determine the acceptability, reliability, and cutoff ranges for these and similar self-administered clinical and non-clinical screening instruments in incarcerated juvenile populations.

Finally, results of this research might hold implications for the manner in which staff training resources are allocated within juvenile correctional facilities and ultimately improve identification of youths' suicide risk factors, and timely referral and treatment for incarcerated juveniles with suicidal ideation, suicide attempts, and mental and/or substance use disorders.

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Table 1
Demographic and Background Characteristics of Participants (N = 76)

	Variable	Percentage
Gender	Male	78
	Female	22
Education level	High school	12
	Some college	14
	Associate's degree	18
	Bachelor's degree	41
	Some graduate work	16
Years employed as a JPW	<2	24
	2-6	29
	7-12	23
	13+	28
Prior work at DCYF	Yes	14
	No	86
Prior work in a medical setting	Yes	32
	No	68
Prior work in a mental health setting	Yes	35
	No	65
Prior clinical training	Yes	28
	No	72
Career interest in social services	Yes	31
	No	69
Career interest in law enforcement	Yes	45
	No	55

JPW = juvenile program worker

DCYF = Department of Children, Youth, and Families

Table 2
Responses of JPW Staff to Knowledge/Attitudes Measure at Pre- and Post-Training

Item	Strongly agree		Agree a little		Disagree a little		Strongly disagree		df	x ²
	n	%	n	%	n	%	n	%		
Youth use suicide to manipulate/ con others	Pre	30	40.5	28	37.8	6	8.1	10	13.5	5.84
	Post	48	58.5	21	25.6	7	8.5	6	7.3	
Suicidal youth should be referred for evaluation	Pre	64	85.3	10	13.3	0	0.0	1	1.3	1.56
	Post	75	90.4	6	7.2	0	0.0	1	1.2	
There is a need for increased MH treatment in JJS youth	Pre	54	72.0	16	21.1	4	5.3	1	1.3	6.57
	Post	69	83.1	14	16.9	0	0.0	0	0.0	
JJS youth have more MH problems than non-JJS youth	Pre	39	53.4	27	37.0	6	8.2	1	1.4	29.27**
	Post	74	91.4	7	8.6	0	0.0	0	0.0	
JJS youth should undergo formal MH screening at intake	Pre	67	88.2	7	9.2	0	0.0	1	1.3	1.77
	Post	78	94.0	5	6.0	0	0.0	0	0.0	
Screening & ongoing assessment is vital to suicide prevention	Pre	59	79.7	14	18.9	1	1.4	0	0.0	1.46
	Post	70	84.3	13	15.7	0	0.0	0	0.0	
Staff training & communication are vital to suicide prevention	Pre	67	88.2	8	10.5	0	0.0	0	0.0	0.05
	Post	75	90.4	8	9.6	0	0.0	0	0.0	
Nurse/medical staff are easily manipulated/conned by youth	Pre	24	32.4	31	41.9	13	17.6	6	8.1	0.67
	Post	29	34.9	33	39.8	12	14.5	9	10.8	
MH staff are easily manipulated/ conned by youth	Pre	16	21.6	32	43.2	16	21.6	10	13.5	2.93
	Post	24	29.6	30	37.0	12	14.8	15	18.5	
Youth should receive substance abuse education/prevention training	Pre	62	82.7	13	17.3	0	0.0	0	0.0	1.37
	Post	71	85.5	11	13.3	1	1.2	0	0.0	

Item	Strongly agree		Agree a little		Disagree a little		Strongly disagree		df	χ^2
	n	%	n	%	n	%	n	%		
Better MH care fosters rehabilitation	Pre	57	76.0	16	21.3	2	0	0.0	2	9.15*
	Post	77	92.8	6	7.2	0	0	0.0	2	9.15*

MH = mental health; JJS = juvenile justice system involved.

* $p < .05$
** $p < .01$

Table 3
Responses of JPW Staff to Item Regarding High-risk Periods for Suicidality among Juveniles

Item		Agree		Disagree		Uncertain		%	df	χ^2
		n	%	n	%	n	%			
Initial detention	Pre	72	96.0	1	1.3	2	2.7	2.7	2	3.34
	Post	82	100.0	0	0.0	0	0.0	0.0	2	
Transfer for court appearance	Pre	53	69.7	5	6.8	15	20.5	20.5	2	10.59**
	Post	72	86.7	5	6.3	3	3.8	3.8	2	
Return to the juvenile facility	Pre	71	94.7	3	4.0	1	1.3	1.3	2	3.57
	Post	80	97.6	0	0.0	2	2.4	2.4	2	
Sentencing	Pre	69	93.8	3	4.1	2	2.7	2.7	2	3.89
	Post	81	98.8	0	0.0	1	1.2	1.2	2	
Receipt of new legal problems	Pre	61	84.7	3	4.2	8	11.1	11.1	2	6.97*
	Post	79	96.3	0	0.0	3	3.7	3.7	2	
Receipt of bad news	Pre	71	97.3	0	0.0	2	2.7	2.7	1	0.47
	Post	81	97.6	0	0.0	1	1.2	1.2	1	
After humiliation/rejection	Pre	71	94.7	2	2.7	2	2.7	2.7	2	2.68
	Post	81	98.8	0	0.0	1	1.2	1.2	2	
Isolation/segregation	Pre	66	89.2	2	2.7	6	8.1	8.1	2	6.71*
	Post	81	98.8	0	0.0	1	1.2	1.2	2	
Prolonged stay in a facility	Pre	55	74.3	10	13.5	9	12.2	12.2	2	9.75***
	Post	76	92.7	3	3.7	3	3.7	3.7	2	
Untreated MH/substance abuse	Pre	70	93.3	0	0.0	5	6.7	6.7	1	3.16
	Post	81	98.8	0	0.0	1	1.2	1.2	1	

$p < .10$
**
 $p < .05$
*